By the time I returned from grand rounds this morning, my patient had already arrived for neuropsychological testing. Our administrative assistant handed me a folder and said she had already prepared the test battery. I thanked her, but when I opened the folder I was surprised to see about 75 pages of medical records.

“Sorry, maybe I’m confused, is this an IME?” (independent medical evaluation), I asked.

“No, but there was an accident,” she answered.

“Ah,” was my reply. We exchanged a look. And we understood one another.

What I understood was that this case was going to be another ‘backdoor forensic evaluation’ (BFE) – as they’ve come to be called in some circles. To those unfamiliar, BFEs occur when patients undergo a treatment oriented evaluation (TOE) that will be billed to their health insurance, but there exists an expectation the evaluation findings and report will be material to a pending or in-progress legal proceeding.

My guess is this phenomenon is most familiar to clinical neuropsychologists (who also do forensic work), but I suspect clinical psychologists are not per se immune. A patient might schedule a generic psychological evaluation, but on evaluation day it becomes clear the assessment is needed for workplace fitness, drug treatment, or – heaven forbid – child custody.

Unfortunately, BFEs are much more than a minor nuisance. They raise, for the practitioner, a variety of ethical, logistical, financial, and legal issues too numerous and complex to completely detail in this column. Many of these stem from inherent differences between traditional TOEs and an assessment for a specific legal question (a forensic mental health assessment or FMHA). These differences have been well documented elsewhere, and are beyond the scope of this writing. A few particularly staggering issues created in the situation of a BFEs are worth highlighting, though.

Putting the patient first, note that BFEs can ultimately do a disservice to the examinee. In FMHAs requested by an examinee’s attorney, the results can be protected as work product. Thus, if the evaluation results would not help the examinee prevail in the legal proceeding, the attorney can ask that no report be written, which means the opposing side will presumably have no knowledge of the evaluation having occurred. (While this may feel unsettling to those unfamiliar with work product privilege, the courts have ruled it unjust to force examinees to generate (i.e., pay for) evidence (e.g., evaluation findings) that would ultimately harm them in legal proceedings).

Moving to issues of logistics and finances, not all BFEs take the course illustrated in the opening dialogue. Sometimes, you are dealing with what I’ll call an after-the-fact BFE. That happens when the psychologist authors a TOE, only to be subpoenaed weeks or months later demanding testimony based on the report. This is problematic because, while health insurance generally pays for TOEs, it does not reimburse for FMHAs, and certainly not for courtroom or deposition testimony. It is also problematic because FMHAs typically include a thorough review of records, well beyond what is typical practice in treatment-focused evaluations. Thus, when psychologists learn of a BFE after-the-fact, it can place them in the undesirable position of choosing the expense of (1) unpaid time off for unpaid courtroom preparation and testimony; (2) fighting a subpoena or court order to furnish unpaid testimony; or (3) potentially defending

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professional has deemed him not a threat to his coworkers. If legal involvement is unclear, it is perfectly reasonable to ask whether the individual is involved in litigation. If so, one can try to convey the broad strokes of why it might be better to have his or her attorney schedule the evaluation. This may prove less than fruitful, so it may be worthwhile to offer speaking with the attorney directly. Although it means more time out of the clinician’s day, talking to the attorney is not time wasted; in those conversations, one can educate attorneys about why they may prefer to have the evaluation go through their office, while also giving notice about the limitations of a TOE if they instruct their clients to still schedule and bill health insurance. The former is more for the attorney, and the latter is more for the clinician, though both help make one’s professional life easier.

If the previously described screening fails for one reason or another (maybe at the time of the phone call the patient was not involved in litigation, but now she is) the clinician must be reactive rather than proactive.

In the case of a before-the-fact BFE, where the evaluation has yet to commence, the clinician has a choice. There are several ethically defensible courses of action, but the only one that results in a day’s pay is if the clinician can connect with the attorney and formalize the initiation of an FMHA. The other easily ethically defendable options are to cancel the evaluation with the hope of rescheduling it as an FMHA at a later date, or to conduct the evaluation to the standards of an FMHA, not billing insurance, and hope the attorney will take ownership of the initiated evaluation after-the-fact. Obviously, one option risks a ‘wasted’ day without an examinee, and the other option risks a ‘wasted’ examination that may never materialize. It goes without saying that these are difficult choices, especially in private practices or small operations where the loss of an hours-long evaluation noticeably affects net earnings.

In the case of an after-the-fact BFE, where a treatment oriented evaluation has been completed, health insurance has paid the bill, and now the clinician is being asked (or ordered) to testify, options may be more limited. It may be tempting for the clinician to try and work with counsel, sending over a fee schedule and offering to review records and, if needed, testify. This is problematic, though, given the many ways in which TOEs are different than FMHAs, with differences beginning

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right at the start with notification of purpose and limits of confidentiality being explained to the examinee. Thus, rather than trying to make a TOE hop tracks to be an FMHA, the most ethically and legally defensible course of action is to comply with any court order or subpoena (assuming the examinee consents), acknowledging (e.g., in testimony) the many limitations inherent to testifying about a TOE rather than an FMHA (e.g., “No, I did not review any of plaintiff’s discovery… Yes, it is entirely possible information therein could alter my opinion.”)

Other than that, the clinician might think about including a statement in all TOEs communicating to any consumer that, if the clinician is subpoenaed or otherwise required to testify, the demanding party assumes responsibility to pay associated fees. That might work; it might also take some effort to get that bill paid. And if the reader is thinking that sounds more like another preventative rather than reactive step then, well, you’re right.

To summarize, BFEs are problematic for psychologists for ethical, logistical, legal, and financial reasons. The best defense is to recognize BFEs proactively at the scheduling stage which, for better or worse, may actually rest with scheduling staff rather than psychologists. Fortunately, some mechanisms exist that allow psychologists to address BFEs reactively as well, though these are limited, and many options are less than desirable. In any case, it is important to know about BFEs as a phenomenon, and to have a plan for what to do when they arise.